Before The
FEDERAL COMMUNICATIONS COMMISSION
Washington, DC 20554

In the Matter of	)	
	)	WC Docket No. 18-213
Promoting Telehealth for Low-Income Consumers	)	

COMMENTS OF MUSC AND PCC

MUSC[1], in collaboration with PCC[2], is grateful for the opportunity to submit these comments in response to the Notice of Proposed Rulemaking (Proposed Rule) released on July 30, 2019, by the Federal Communications Commission (Commission) on the proposed Pilot program promoting telehealth for low-income consumers. MUSC and PCC applaud the Commission for the vision to enhance much-needed broadband-enabled telehealth services to improve access to high quality health care for rural and vulnerable populations. MUSC and PCC have a long history of working collaboratively to enable the dissemination of telehealth services in rural areas. For the purposes of this response, MUSC has focused on replying regarding the items concerning support for the telehealth services, as well as experience with the cost of devices and their connectivity. PCC has extensive experience administering federal subsidies for rural broadband, and is well positioned to contribute comments regarding the broadband support and associated administrative elements.

INTRODUCTION

What follows are detailed comments based on the questions posed by the Commission in its Proposed Rule. A primary driver of our comments is that in South Carolina we are prepared to significantly expand our interventions in order to respond to this opportunity. However, we are concerned that level of broadband extension may outstrip the level of service

[1] Founded in 1824, The Medical University of South Carolina (MUSC) continues the tradition of excellence in education, research and patient care as the only academic health sciences center in the state of South Carolina.
[2] Established in 2010, Palmetto Care Connections (PCC) is a non-profit organization that provides technology, broadband, and telehealth support services to health care providers in rural and underserved areas in South Carolina.

delivered if there are no allowable funds to go towards program growth and outcomes monitoring. The points of emphasis are summarized below:

1. Many of the requests for comment reflect a pivot towards funding broadband initiatives but not the clinical program or evaluation related to the initiative. We feel strongly that programs leveraging the funding should be well positioned to operate at a scale large enough to achieve population level outcomes and should be resourced to robustly evaluate such outcomes. Our past experience with technology-only funding—including broadband-only funding—is that while connectivity is established, telehealth service delivery is entirely lacking or lags behind by years. Furthermore, the current reimbursement landscape leads us to believe that that entities able to provide telehealth services commensurate with the scale of the broadband funding, will not find participating in the Pilot program feasible unless administrative and evaluation personnel can be in-part supported by Pilot funds.
2. A second focus of interest regarding this request for comments is whether funding should be applied for bundled technologies and broadband connectivity. Within our comments there is an emphasis affirming that successful programs and effective devices often leverage cellular capability built into the devices, and that this has greatly enhanced utilization. Thus, in addition to supporting broadband connections directly to patients' homes, the Pilot program should also have the flexibility to leverage cellular connectivity when deemed most appropriate for a telehealth program (e.g. diabetes remote patient monitoring).
3. A third major point in our comments is in regard to the allowances for funding of devices. While some reimbursement for devices is now available, this is typically not consistent across payers and does not cover the true costs of the equipment. This is particularly true for cellular enabled devices. Without device costs, the broadband coverage would be broader than the ability of the program to be dispersed to an equivalent level.

CLINICAL FOCI OF PILOT PROGRAM

Narrowing the clinical focus of this Pilot program to chronic disease management is an important and reasonable objective. This has the potential to result in a variety of innovations for this often under addressed area of healthcare. It should be noted, however, that the conditions listed in the Proposed Rule (other than pregnancy) are typically life-long conditions

and thus longer durations of evaluation will be required to understand the long-term impact of any interventions intended to improve outcomes in the chronic disease management domain.

IMPORTANCE OF CELLULAR CONNECTIVITY IN CONNECTED CARE SERVICES

With the growing use of wearable devices and patient-facing technology, cellular connectivity is increasingly important. The populations of interest to the Commission often do not have broadband access at the individual patient level. In our experience, cellular connectivity is more readily available and thus provides a more reliable connection between healthcare provider and patient. Remote connectivity, in the absence of cellular technology, requires direct wireless internet connectivity or Bluetooth connection to a connection.

Moreover, as we have learned in MUSC's diabetic remote patient monitoring (RPM) program, many RPM services that utilize cellular connectivity package the cellular connectivity with the device/product. RPM products utilizing broadband often do not include internet service as this is typically something privately contracted between a service provider and end-user. For targeted patient populations, this is a barrier, and cellular connectivity often proves to be the best solution to ensure patients have a reliable connection.

Broadband technology has been the primary driver of telehealth dissemination and delivery thus far, but often times relying only on broadband access alone puts at risk a significant proportion of low income and rural patients who do not have access to even the most basic technology: a smartphone. Pew Research suggests that roughly three in ten low income households (<$30,000/year) do not own a smartphone, and fewer own a computer or tablet, with similar findings for rural adults[3,4]. In the MUSC diabetes RPM program, 83% of the 784 patients report household income of less than $25,000, and we have successfully engaged this population using a care bundle including mobile device, supplies and access to mobile service. We believe it is critical to include mobile technology with device and service bundles as a program reimbursement option to continue to engage low income and rural populations in diabetes RPM.

[3] https://www.pewresearch.org/fact-tank/2019/05/07/digital-divide-persists-even-as-lower-income-americans-make-gains-in-tech-adoption/
[4] https://www.pewresearch.org/fact-tank/2019/05/31/digital-gap-between-rural-and-nonrural-america-persists/

COSTS ASSOCIATED WITH REMOTE PATIENT MONITORING

The Commission seeks comment as to what extent health care providers are already funding patient broadband connections for connected care services and what the costs are associated with funding those connections.

In MUSC's diabetic RPM program which utilizes cellular connectivity, the fee for connectivity is approximately $8.50/patient/month. In this program, these costs are covered through grant funding. This monthly incurring cost and insecure chronic funding mechanism is a threat to ongoing connectivity between provider and patient. It also prevents the program from scaling to reach more patients. Many groups across the nation are working to perform cost analysis with utilization of recently instituted reimbursement codes in the hopes that the connectivity costs will ultimately be afforded through revenue/reimbursement, but it is far from certain that the combination of connectivity and personnel costs will be sufficiently reimbursed by new compensation codes.

For other direct-to-patient programs sponsored by MUSC—such as some of MUSC's behavioral telehealth programs—connectivity is provided through use of cellular hotspots. Programs utilizing these services typically pay for this connectivity through grant mechanisms rather than being covered by providers offering the services. Thus, funding is insecure and unsustainable.

COMMENT ON DEFINING "TELEHEALTH" AND "CONNECTED CARE"

We suggest the Commission adopt the terminology "telehealth" rather than "telemedicine" for this Pilot program. Much of the day-to-day management of the listed chronic conditions is optimally care done by an interdisciplinary team that might include nurses (e.g., for diabetes management) or mental health counselors (e.g., for behavioral health conditions). The term "telehealth" is more inclusive of the broader ways in which technology is used to support clinical outcomes of patients.

As currently defined in the Proposed Rule, "connected care" could be read as allowing for workplace, schools, prisons, and other institutions as being potential places of care. If that is not the intent, we argue that defining the service as directly to the patient or the patient's residence would be more precise and aligned with the goals of the Pilot program.

COMMENT ON USE OF FUNDS FOR NON-HEALTH CARE PURPOSES

App-based approaches and other uses of the patient's own device offer great promise for scalability. Commonly, health literacy and education initiatives can be coupled with the clinical service. Additionally, patients with significant chronic health conditions suffer from the effects of social determinant barriers to wellness that may be mitigated through connectivity. Moreover, allowing non-health care connectivity also provides opportunities for children and other household members to use the connection to support research, education, remote employment, and other avenues for civic engagement, all of which enable an individual to achieve a more productive and healthier lifestyle. In short, we would encourage allowing the use of internet capability for non-health care reasons for qualifying patients because social determinants of health play a vital role in improving population health overall.

PACKAGES USED FOR CONNECTED CARE SERVICES

End-user devices and hardware are only as good as the communication/connectivity between the patient (with the device/hardware) and the receiving healthcare provider. Many cellular connectivity platforms offer bundled services: device, cellular connectivity, and data platform. Health care providers engaging in this type of care often do so under grant funding or bundled payment mechanisms such as that of an Accountable Care Organization.

Additionally, based on MUSC' experience with RPM for diabetes and mental health conditions, we believe it is critical to include mobile technology with device and service bundles as a program reimbursement option. This, alongside the continued build out of broadband, will allow providers to better engage low income and rural populations in RPM.

FUNDING NETWORK EQUIPMENT

With the revamping of the Rural Healthcare program and the change to once per year filing windows, it has become virtually impossible from the perspective of Palmetto Care Connections (PCC) to receive the funding for network equipment under the Healthcare Connect Fund. PCC proposes developing a method for consortia to review previous site purchases and advise on whether current hardware is adequate to perform the eligible telehealth and RPM services alongside normal day-to-day operating functions. In the event that a health care provider's current hardware is deemed inadequate, an application process could be used to

request a percentage funding for upgraded equipment. Additionally, PCC suggests the Commission determine a minimum standard for hardware specifications required to meet the goals of the telehealth and RPM services.

NECESSITY FOR CLINICAL, EVALUATION, AND ADMINISTRATIVE FUNDING

We strongly suggest that clinical service support, evaluation expertise, and administrative personnel costs be incorporated into the Pilot funding mechanism. The Proposed Rule appropriately places a heavy emphasis on gathering clinical outcomes across the Pilot program. If the Pilot program only funds connectivity and does not support other aspects of the telehealth services connected to that connectivity, it will be difficult to achieve meaningful scale, resulting in lack of breadth and depth of outcomes envisioned by the Commission.

Moreover, the Proposed Rule states: “As the Commission has previously explained, past experience in the RHC support programs and RHC Pilot program demonstrates that ‘[health care providers] will participate even without the program funding administrative expenses.’” However, based on PCC’s experience, until 2016 participation in the RHC programs was quite low. Furthermore, many organizations participating in the RHC program do utilize FCC funds for administrative and personnel costs. In reality, many consultants or consortiums are receiving as much as 35% of the circuit cost to cover these administrative costs. This further suggests the importance that the Commission allow budgets to include costs beyond connectivity.

COMMENT ON COVERAGE OF END-USER DEVICES AND MEDICAL EQUIPMENT

We strongly urge the Commission to allow medical devices and other equipment to be considered eligible for funding. While many applicants may currently have opportunity for external funding under grants, these external funds are often granted under the premise of new investigation. We are in a critical position nearing 2020 as it is clear that end-user devices and telemedicine are effective yet not all payers are covering or reimbursing for these services, leading providers caught in a vacuum of financial sustainability. Including devices and other equipment among eligible costs would allow MUSC to further scale its RPM programs, providing invaluable data that would not only inform the work of the Commission but also influence payers to increase their coverage of end-user RPM and other devices.

FLEXIBILITY OF PILOT COSTS & FUNDING PERIOD

Because reimbursement for telehealth varies widely across the United States and is largely informed by state rather than federal legislation, it is important that the Commission allow flexibility in how Pilot projects develop and apply their budgets so as to avoid excluding organizations in states with less favorable telehealth legislation. For example, some organizations would be able to recoup costs of the clinical services through third-party payer reimbursement whereas others would be unable to cover these costs through this mechanism and thus be unable to participate in this Pilot.

Additionally, we encourage the Commission to allow funding to go toward high-quality reporting, outcomes generation, and analyses of these outcomes. In fact, the Commission may consider requiring outcome reporting to include clinical outcomes in addition to patient and provider utilization, costs, etc. This would inform future estimates of need (patient volumes, etc.) as well as clinical benefit and anticipated costs.

In addition to allowing flexibility in how Pilot projects develop and apply their budgets, we encourage the FCC to allow flexibility in how funds are applied across the 3-year period given variability within a given program. For some programs, there may be anticipated start-up costs that would exceed those of maintenance costs. However, uptake may lag at a program's onset. Given the expected fluctuations in cost, flexibility especially for front-loading is encouraged. Depending on how a Pilot program is structured, a tiered approach to funding may be warranted as services and participants increase.

COMMENT ON PER PROJECT CAP

From our perspective, we believe that more important than the budget cap is how funding can be allocated. If budget allocations are permitted only for broadband expansion, it is unlikely Pilot projects will be able to meaningfully scale telehealth services already in place or collect and analyze process of care and outcome data. We support the Commission's comments on allowing a varied portfolio of Pilots with discretion in how individual Pilots develop budgets, which should be scoped to their proposed work plans.

COMMENT ON HEALTH CARE PROVIDER ELIGIBILITY

We would not recommend excluding particular types of healthcare providers a priori but would most importantly require that, in general, participating healthcare providers are well-versed in medical research methods to properly evaluate outcomes associated with connected care. We suggest the Commission require successful Pilot applications describe a clear research/evaluation strategy and why the proposed Pilot team has the requisite expertise to accomplish the research/evaluation plan.

We recommend that geographic restrictions not be limited to rural populations but agree that it is reasonable to consider defining target urban populations (e.g., using HRSA designations such as HPSA or MUA or defining underserved communities based on the ration of primary care providers to patients, or based on average household income). Additionally, we would recommend against eligibility criteria that focus primarily on the healthcare provider's practice (e.g. percentage of uninsured and underinsured patients, or a certain percentage of Medicaid patients). This removes the focus from the patient and would disqualify otherwise eligible and needing patients due to factors out of their control. For example, a patient being seen "pro bono" by a physician might be disqualified.

We also support the Commission giving greater weight or consideration to health care providers who have demonstrated experience providing long-term care to patients or who have appropriate support networks in place to ensure overall care quality (such as those afforded by the Patient-Centered Medical Home).

We would not advise the Commission to limit eligibility in the Pilot program to federally funded telehealth entities such as the Telehealth Resource Centers or Telehealth Centers of Excellence. However, we would advise the Commission to limit eligibility in the Pilot program to organizations with a demonstrable track record in telehealth broadly and in remote monitoring specifically to ensure rapid deployment and timely results.

COMMENT ELIGIBLE SERVICE PROVIDERS

PCC proposes the Commission use the same method for selecting service providers that is currently used in the RHC/HCF programs, whereby the health care provider works with a consultant or consortium to properly vet the service provider. This will help to decrease fraud and ensure efficient spending of funds by unbiased sources.

APPLICATIONS, REQUIREMENTS, AND REVIEW PROCESS

We are in support of the application requirements as outlined in the Proposed Rule. Additionally, based on their experience administering the Healthcare Connect Fund, PCC recommends that the Commission require an application process similar to the FCC Form 460 process.

We also feel the commission should require that if the project is selected, the service provider would be required to obtain the necessary ETC designations. This should be part of the requirements under any RFP process in order to bid on the project.

We also suggest the Commission require evidence that applicants are able to provide for a patient's healthcare needs above-and-beyond the telehealth-supported care. This is important for chronic disease management which often necessitates interventions beyond that enabled by telehealth. The phrase 'long term care' often conveys care settings such as skilled nursing facilities which should not be a prerequisite for applicants. The Commission should require that Pilot applicants are in compliance with the ethical standards for human subjects research as promoted by the Office for Human Research Protections (DHHS) and verified through provision of the applicant's Federalwide Assurances number.

Given the strong emphasis on collecting process and outcomes measures and the importance of rigorous research methodology, the Commission should consider ascertaining whether the National Institute of Health could contribute to the review process. The federally designated telehealth entities could also be valuable contributors to the review process, although individual entities should be excluded from reviewing if they are also applicants to avoid conflict of interest concerns.

Finally, the Commission proposes to focus on four primary program goals through this pilot as outlined in paragraph 70 in the Proposed Rule. We suggest the Commission advise applicants to consider each of these priority areas and specifically request that applicants provide narrative on how these objectives will be accomplished by the proposed Pilot project.

EVALUATION CRITERIA OF PROPOSALS AND SELECTION OF APPLICANTS

The Commission should consider whether and to what extent projects demonstrate return on investment and cost-effectiveness from the perspectives of patients, payers, and providers. Applicants should be permitted to use funds to cover costs related to this important proof-of-concept work.

In terms of evaluating whether a project will primarily reach patients in rural areas, we believe determining travel distance would be just as burdensome as determining individual addresses. Perhaps a better approach would be to follow the census tract information used either by the USDA. Consideration might also be given to program participant's zip code as an indicator of eligibility, along with the prevalence of the health disparity being addressed. Targeting areas where the need is greatest to serve patients with health disparities should be considered during the selection process.

In paragraph 52 of the Proposed Rule, the commission outlines certain chronic conditions as US public health crises and seeks comment on whether these conditions be should be prioritized. We agree with the Commission's assessment, and these crises are especially burdensome in rural and underserved areas. Thus, these seem to be good targets for investment in order to identify novel approaches. There are, however, a wide array of health disparities that exist in rural and underserved populations, and limiting to only a subset of chronic conditions may preclude important innovations with regards to other disease states. Thus, other eligible chronic conditions should not be precluded from the funding.

SELECTION OF SERVICE PROVIDERS

We affirm the Commission's focus on ensuring proper procedures be put in place to limit fraud and abuse. Based on PCC's experience administering the program, we believe the current Healthcare Connect Fund program has the appropriate checks and balances in place to help prevent this abuse. To maintain this, however, we would stress the importance of keeping the services providers on the periphery of the program in order to reduce fraud and abuse.

We agree that the healthcare provider should play the lead role in selecting and procuring a service provider. For larger healthcare organizations such as MUSC, this would not be a problem. However, most rural healthcare providers lack basic IT and the ability to fully manage the vetting of a service provider. In these instances, we believe consortiums—the role PCC currently plays with the Healthcare Connect Fund—could play a role in aiding this vetting process.

COMMENT ON COMPETITIVE BIDDING PROCESS

We are in support of the requirement of a competitive bidding process to select the most cost-effective service. However, if funding is extended to include devices, we would note that

the most cost-effective device may not be the most efficient or most easily adopted by the target population, as MUSC has learned in our diabetic RPM program.

For competitive bidding, PCC encourages the Commission to use the same procedures (i.e. Form 461, securing a Letter of Agency) and also extend the same competitive bidding exemptions for the Healthcare Connect Fund program to the Pilot program. When an exemption applies, ETCs should be required to make their interest in participating in the Pilot program and their service areas publicly available.

COMMENT ON PROPOSED METRICS

We agree that all of the proposed measures outlined in paragraph 80 of the rule are important and worthwhile, although unlikely to be applicable to all connected care solutions. Additionally, many are long-term outcomes are less likely to be impacted by comparatively short-term interventions (e.g. 1-2 years). We suggest that the Commission ensure each applicant outline proposed outcome measures and how these are logically attributable to the proposed interventions. Applicants should consider short-, intermediate-, and long-term outcome measures associated with their proposed interventions. Data collection and analysis plans should be appropriate to the proposed measures.

For example, in MUSC's RPM diabetes program which partners with rural primary care clinics, we use weekly patient transmission rates of blood glucose measures as a key performance indicator to ensure the outcomes we observe are due to the telemedicine aspect of the program. We have deemed that patients who test at least 3 times per week are fully receiving the intended intervention. If patient transmission rate drop, we contact the patient to ascertain reasons. With regards to intermediate outcomes, we assess patient's HgBA1c at Baseline, 6-, and 12-months.

COMMENT ON WAYS UNIVERSAL SERVICE FUNDING COULD PROMOTE IMPROVED HEALTH OUTCOMES

Low income consumers do face budget constraints, and in many cases, this prevents them from accessing needed healthcare services. These same constraints impair healthcare providers in rural areas who cannot directly enable broadband services into their patient's home. Patient specific barriers include patients not having enough minutes or data on the phone plans

to participate in services. Low income patients that are able to participate in fully supported programs see the most improved health outcomes and are more likely to participate.

In the case of MUSC's diabetes RPM program, nurses and/or primary care providers can review patients' blood sugar/blood pressure readings and physicians can contact patients for medication adjustments, thus saving time and effort for both patient and provider. This saves patients return visits to the clinic, which are especially costly if a patient lives in a rural area, has transportation issues, or is unable to take leave from work.

COMMENT ON HOW THE PILOT COULD SUPPORT COST SAVINGS

The Commission seeks comment on how to evaluate potential cost savings through telehealth. In MUSC's diabetic RPM program, observable outcomes include patients being less likely to experience a critical event (e.g. severe exacerbation of diabetes) or being admitted to an ER because critical values are observed by remote monitors and can be addressed prior to a critical event transpiring. Furthermore, titrating a patient's medication every two weeks instead of once quarterly is ground-breaking, in part because it enables much deeper patient engagement and activation in disease self-management. Titrating medication more frequently through remote patient monitoring helps achieve adequate HgA1c results more quickly and engages patients in the process. Additionally, patients seem to test more frequently when they know a provider is looking at their day-to-day results.

AVOIDING DUPLICATION OF FEDERAL EFFORTS TO EXTEND CONNECTIVITY

We agree with the Commission that successful applicants should have a funding portfolio that extends FCC and other federal investments. This funding portfolio should be described by successful applicants. However, the FCC should consider whether the primary objective of this Pilot program is extending broadband access in rural communities, a very important objective, or telehealth outcomes for chronic disease management. If the latter or both, it will be important that FCC funds be eligible for program use beyond broadband access.

REPORTING INTERVALS

We agree that it is imperative for the Commission to enable data collection and analysis to ascertain the success of the Pilot program. Given the emphasis on long-term outcomes, the

Commission should consider having applicants map out a trajectory of outcomes matched to program stage and require successful applicants to provide these outcomes on a biannual basis. It will be important for successful applicants to be able to utilize FCC funds to budget for the costs of such data collection and analysis.

In addition to biannual outcomes reporting, the Commission should consider requesting brief, quarterly progress reports that track key programmatic milestones. Annual reporting of process and outcome data would also be reasonable.

COMMENT ON CLINICAL TRIALS

While the value of well conducted randomized trials is without question, there are a variety of other research designs that can provide important insights into the relative merits of interventions such as telehealth. Indeed, telehealth interventions are often multi-faceted and occur at the level of organizations, providers, and patients. Thus, clinical trials are often not the ideal methodology as they typically seek to control all variables but the target intervention between groups – a near impossibility in many telehealth endeavors. Thus, the Commission should consider study designs that are best suited to specific program objectives.

COMMENT ON DATA FIELDS AND PATIENT MEASURES

We agree with the Commission that the fields outlined in the Proposed Rule are reasonable and important measures to obtain. We suggest the Commission consider cost-savings from a broader array of stakeholders. In addition to patients, savings to third-party payers, providers, and healthcare systems should be considered when feasible. We suggest that the Commission require applicants to stipulate their plans for data acquisition, data quality control, and data security. Successful applicants should be based in organizations with the requisite infrastructure and expertise to meet these requirements and demonstrate these qualities in the application's narrative.

We agree with the Commission that patient reported measures are important to collect. We suggest that these types of measures rarely change over time on a per patient basis and that each participating patient complete the survey once or at most annually.

Additionally, the measures identified by the Commission in paragraph 91 of the Proposed Rule are important in direct-to-patient telehealth programs. There are additional measures which influence the success of these types of telehealth services and should be

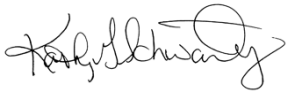
captured, including patient demographics, social determinants of health, transportation issues, and numerous clinic characteristics. We suggest the Commission require applicants to demonstrate expertise in appropriate measures and to provide a data collection plan. This will allow any results obtained from the Pilot program to be contextualized to the specific types of care settings and thus extrapolated appropriately.

CONCLUSION

We wish to thank the Commission for the opportunity to comment on the Proposed Rule and look forward to final guidance from the Commission in the near future. The excitement around this opportunity continues to grow in our state, and we hope the collaboration demonstrated in these responses reflects our commitment to leverage this opportunity to improve the health of the population we serve.

Respectfully Submitted,

James T. McElligott, MD, MSCR
Executive Medical Director
Center for Telehealth
Medical University of South Carolina



Kathy G. Schwarting, MHA
Chief Executive Officer
Palmetto Care Connections

Dee W. Ford, MD, MSCR
Program Director
National Telehealth Center of Excellence
Medical University of South Carolina

William P. Moran, MD, MS
Professor and Director
Division of General Internal Medicine
Medical University of South Carolina

###

ABOUT MUSC CENTER FOR TELEHEALTH

The mission of the Medical University of South Carolina's (MUSC) Center for Telehealth (Center) is: "Telehealth for effective and efficient care." This Mission of the Center is to improve the ability of MUSC to deliver exceptional health care to those in need by leveraging technology to extend the reach and improve the quality of our healthcare services. The Center intends to maximize resource efficiency and establish innovative growth of technologies and their applications.

The Center is supported by South Carolina State Legislature appropriations as well as additional grants and revenue. It is the founding member and headquarters of the South Carolina Telehealth Alliance, a collaboration established to empower care providers and patients across the state to effectively use telehealth. The MUSC Center for Telehealth is also one of two federally recognized National Telehealth Centers of Excellence (COE) as awarded by the Health Resources & Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services. MUSC was awarded this national designation because of the Center for Telehealth's successful telehealth programs with a high annual volume of telehealth visits, substantial service to rural and medically underserved populations through telehealth, and its financially sustainable telehealth models.

As the leading academic health center in a state with a large low income, rural and underserved population, MUSC has extensive experience using telehealth methods across the continuum of care in statewide efforts to improve access to primary care, acute care, post-acute care and other care locations (e.g. skilled nursing, schools, prisons). Through this experience, MUSC has gained unique insight into the attributes required to advance a telehealth agenda as it provides 77 unique telehealth services to over 275 sites in 40 SC counties. Care settings include 40 hospitals, 126 community clinics, and 92 other sites, including 80 schools, and alternative sites such as nursing facilities, prisons and patients' homes, with 78% of sites being in partially or fully medically underserved regions of South Carolina. MUSC's number of annual telehealth interactions has grown from 1,078 in 2013 to over 290,000 in 2018.

ABOUT PALMETTO CARE CONNECTIONS

Established in 2010, PCC is a non-profit organization that provides technology, broadband, and telehealth support services to health care providers in rural and underserved areas in S.C. PCC is the Consortium leader of the Palmetto State Providers Network (PSPN), a broadband consortium which facilitates broadband connections throughout the state. In this role,

PCC helps healthcare providers gain access to the FCC's Healthcare Connect Fund program which facilitates subsidized broadband. Members of the PSPN Consortium participated in the Rural Health Care Pilot Program when it was initially established but then transitioned over to the Health Care Connect Fund. In June of 2019, PCC filed for more than 400 circuits on the behalf of health care providers in South Carolina.